Kind Eyecare: ***Confidential Patient Registration***

Patient Name: _____ Date of Birth: _____
(Please Print) Last Name First Name Middle Initial (mm/dd/yyyy)

Marital status: _____ Gender: Male Female Transgender

Home Address: _____

Phone #: Home _____ Work _____ Mobile _____

Email Address: _____ How did you hear about us? _____

Race: Asian ___ Black ___ White ___ 2 or more ___ Other _____ Ethnicity: Hispanic ___ Non-Hispanic ____

Employer: _____ Occupation: _____

Office Address: _____

Primary Medical Insurance Name: _____ ID #: _____ Group #: _____

Subscriber Information (*please skip if Self****):***

Name: _____ Employer: _____

D.O.B: _____ Relationship to Patient: _____ Work phone: _____

Secondary Medical Insurance: _____ ID #: _____ Group #: _____

Subscriber Information (*please skip if Self****):***

Name: _____ Employer: _____

D.O.B: _____ Relationship to Patient: _____ Work phone: _____

Workers Compensation (if applicable):

Name of Insurance: _____ Date of Injury: _____

Insurance Company Address: _____

Claim adjuster: _____ Phone #: _____ Claim #: _____

Employer (at the time of accident): _____

Employer Address: _____

Employer contact: _____ Phone #: _____

"I request that payment of authorized Medicare benefits be made to either me or on my behalf to KLH eyes LLC for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services."

"I authorize KLH Eyes LLC and its billing agents to submit claims on my behalf to my insurance carrier, with payment of insurance benefits being paid to KLH Eyes LLC. I permit a copy of this authorization to be used in place of my original signature and authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents or other insurance companies any information needed to determine benefits payable as outlined by HIPAA. I will be fully responsible for payment if insurance denies reimbursement. I will further be responsible for payment of fees in the event I have failed to provide my most current insurance information at any visit."

Patient and/or Guardian Signature: _____ **Date**: _____

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Patient's Eye History (Please answer Yes or No if patient has these condition):

Cataract(s): _____ Glaucoma: _____ Macular degeneration: _____ Corneal disease: _____ Keratoconus: _____

Strabismus or "Lazy eye" or "Eye Turn": _____ Amblyopia: _____ Retinal detachment: _____ Dry eyes: _____

Patient's Medical History (Please answer Yes or No if patient has these condition):

Neurologic condition: _____ Heart disease: _____ Diabetes Mellitus: _____

Stroke: _____ Liver condition: _____ High Blood Pressure: _____

Headache: _____ Kidney condition: _____ High Cholesterol: _____

Ear/Nose/Throat conditions: _____ Urinary condition: _____ Bleeding disorder: _____

Year-Round/Seasonal Allergies: _____ Thyroid disease: _____ Anxiety/Depression: _____

Asthma or Breathing conditions: _____ Cancer: _____ Autoimmune Conditions: _____

Have you ever been hospitalized or had surgery? And When? _____

Do you smoke/use Tobacco? _____ Do you consume alcoholic beverages? (circle one) None/Occasional/Daily/Weekly

Referring Doctor: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Please list all medications you are taking (any prescriptions, over-the-counter medications, vitamins and minerals, or herbal/dietary nutritional supplements) including Dosage, Frequency, and Route (i.e. eye drop or by mouth):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Are you Allergic to any medications? Yes---No If Yes, what was it and the reaction: _____

Emergency Contact: _____ Phone: _____

Please family member(s)/representative(s) you are authorizing to access you protected health and financial information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient and/or Guardian Signature: _____ **Date**: _____

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Appointments: Appointments vary in length, please allow at least 1½ hours for the visit. Patients are dilated at least yearly. Following dilation, patient may experience light sensitivity and difficulty reading for a few hours so please arrange for a driver as needed. Please bring a driver's license/identification, and all applicable insurance cards.

Medical Exams: Patients who are experiencing a medical eye issue, have had previous eye surgery or have a systemic disease (such as diabetes, Bell's palsy, hypertension, etc.) will require a medical exam which is billed to medical insurance. Medical exams *do not* include an eyeglass (refraction) or contact lens prescription.

Routine Vision Eye Exams: We are participating with limited insurance company for vision. Please inquire if interested.

Refraction: Refraction is a test to generate an eyeglass prescription. Eyeglasses prescription is *not* part of the medical exam. Most insurance plans do not cover refraction. The $50.00 refraction fee is collected at the time of service.

Contact Lens Evaluation: A contact lens evaluation is needed to generate a contact lens prescription; it is in addition to the eye exam and contact lenses. If a patient requests a contact lens prescription, please ask a member of our staff or visit KindEyecare.com for more details.

Co-payments/Co-insurance/Deductibles: Patients are responsible for all co-payment, co-insurance and deductible amounts at the time of service. We accept cash, check, debit and credit cards. *Patient will be responsible for all fees related to a returned check for non-sufficient funds*.

Collections: All balances beyond 90 days past due will be sent to our collection agency. You will be financially responsible for all collection and legal fees that our office incurs to collect the outstanding delinquent balance.

Primary Care Referrals: Depending on the patient's insurance plan, a referral from a primary care physician may be required. Patients who require a referral from the Primary Care Physician and do not have a referral will be required to pay out of pocket at the time of service or reschedule the appointment.

Cancellations & No-show: We request that patients call and cancel/reschedule their appointment at least 24 hours in advance to allow other patients the opportunity to be seen and to accommodate emergency appointments. Patients who do not cancel or reschedule their appointment at least 24 hours in advance will be charged a $25.00 fee.

Records: To be compliant with federal regulations, medical records will be kept for *seven years*. After seven years, records will be properly disposed of in a manner which protects patient confidentiality. A patient may request a copy of their records for a nominal fee. Please allow up to 15 business days for delivery.

Forms/Letters: Any forms or letters to be completed/dictated by our staff are *not* covered by insurance and may be subject to a $10.00 administrative fee (such as workers compensation, disability, DMV, aviation, school forms, etc).

Medication Refills: Please request medication refills during the appointment. Phone or fax refill requests may be subject to a $10.00 fee. Please contact the office *three days* in advance of running out of your medication.

Notice of Privacy Practices: Federal law mandates that medical offices provide access to their Notice of Privacy Practices. This notice outlines patient rights and our methods for protecting patient health information. By signing below, the patient (or legal guardian) has acknowledged that they have reviewed the Notice of Privacy Practices on our website (KindEyecare.com) or have received a copy at our office. Additional copies are available upon request.

I understand and accept all terms and conditions of my examination and the financial policy.

Patient and/or Guardian Signature: _____ **Date**: _____